Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTHEAST HEALTH SERVICES INC
PO BOX 170336
DALLAS TEXAS 75217

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
DALLAS ISD

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-05-4080-01

MFDR Date Received
February 3, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Table of Disputed Services: "CPT code 97032 was used to report the Matrix system; this is the 2nd page of documentation with each date of service. Unless a misc. code is used in the most accurate code we could find for this service. CPT code 97799 was used to report the Lumbar Spinal Decompression; this is the 2nd page of documentation with each date of service. Please see documentation marked Exhibit 4 from Trailblazer confirming that this is a valid CPT code. [99211] Denied as 'not documented', please see attached documentation for each date of service. In addition, please see documentation marked Exhibit 1, 1A, 1B, and 1C confirming that this was billed within Medicare Fee Guidelines. [99070-73] This report is required by TWCC. [97110] Denied as global."

Amount in Dispute: $1,249.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 was placed in carrier representative box on February 9, 2005. The insurance carrier did not respond to the DWC060 request. The division will therefore issue an F&D based on the information presented to the Medical Fee Dispute Resolution section.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2004 through April 28, 2004	97032, 64450-TN, 97032, 97799 (2 units) and 99211	$1.249.24	$88.46

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Former 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.

3. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
4. 28 Texas Administrative Code §129.5 sets out the Work Status Report guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - Date of service: February 3, 2004
     O – Denial after reconsideration. Upon review of your request for reconsideration, no additional benefit is recommended.
   - Date of service: February 16, 2004
     G90 – The insurance carrier did not provide an explanation on the EOB dated 9/8/2004.
   - Date of service: February 23, 2004
     N2 – N-Not appropriate documented. Invalid or missing CPT code or HCPC code.
     D91 – D-Duplicate bill. This appears to be a duplicate bill.
   - Date of service: February 25, 2004
     N11 – N-Not appropriately documented.
     D91 – D-Duplicate bill. This appears to be a duplicate bill.
     N2 – N-Not appropriate documented. Invalid or missing CPT code or HCPC code.
   - Date of service: February 27, 2004
     N2 – N-Not appropriate documented. Invalid or missing CPT code or HCPC code.
     D91 – D-Duplicate bill. This appears to be a duplicate bill.
   - Date of service: March 1, 2004
     N11 – N-Not appropriately documented.
     D91 – D-Duplicate bill. This appears to be a duplicate bill.
     N2 – N-Not appropriate documented. Invalid or missing CPT code or HCPC code.
   - Date of service: March 5, 2004
     No EOBs were submitted for CPT code 99211 and 99070-73.
     N2 – N-Not appropriate documented. Invalid or missing CPT code or HCPC code.
     D91 – D-Duplicate bill. This appears to be a duplicate bill.
   - Date of service: April 28, 2004
     N72 – N-Not documented. Documentation must include treatment provided (with days of week), response to treatment, progressive overall improvement of symptoms; failure to respond to treatment should reflect a change of the treatment plan.

Issues

1. Did the requestor submit an updated table of disputed services?
2. Did the requestor submit documentation to support fair and reasonable reimbursement for CPT code 97799?
3. Did the requestor bill for unbundled services?
4. Did the requestor bill for a DWC-73 according to 28 TAC §129.5?
5. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted an updated table withdrawing several dates of service. The original disputed amount was $4,200.98. The updated table of disputed services indicates the new disputed amount of $1,249.24.
2. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection.
   - The requestor seeks reimbursement for CPT code 97799 x 2 units/each for dates of service February 23 2004, March 5, 2004, March 1, 2004 and March 5, 2004.
   - CPT code 97799 is defined as "Unlisted physical medicine/rehabilitation service or procedure."

- Review of the Medicare Fee schedule does not value CPT code 97799; therefore reimbursement is subject to Rule 134.1.

Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The CPT code 97799 does not have a Medicare assigned value.
- Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
- In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs supports the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

3. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exists. Review of the documentation finds:
   - Date of service, February 3, 2004; disputed CPT code 97032; CPT codes billed 98940, 98943, 97140, 97016, 97035 and 97032. No CCI edit conflicts were identified for CPT code 97032.
   - Date of service, February 16, 2004; disputed CPT code 64450-TN; CPT codes billed 97035, 97110, E0745, 99211, 97032 and 64450. CCI Edit - Procedure 97110 and component procedure 64450 are unbundled. The Standard Policy Statement reads "Misuse of column two codes with column one code". This E/M service, Procedure 99211, should not be billed on the same date of service as Procedure 64450 without modifier 25 – 25. Reimbursement is therefore not recommended for CPT code 64450.
   - Date of service, February 25, 2004; disputed CPT code 97032; CPT codes billed 98940, 97016, 97035, 97799, 97032 and 97139. No CCI edit conflicts were identified.
   - Date of service, March 1, 2004; disputed CPT codes 99211 and 97032; CPT codes billed 97140, 97016, 97035, 97799, 99211, 97032 and 97139. No CCI edit conflicts were identified.

- Date of service, March 5, 2004; disputed CPT codes 99211 and 99070-73; CPT codes billed 99212, 97140, 97139, 97016, 97799 and 97035. No CCI edit conflicts were identified for CPT code 99070-73. The requestor seeks reimbursement for CPT code 99211, however billed the insurance carrier CPT code 99212. The insurance carrier has not had the opportunity to audit CPT code 99211. Therefore CPT code 99211 is not eligible for Medical Fee Dispute Resolution review.
- Date of service, April 28, 2004; disputed CPT codes 97110 x 2 units; CPT codes billed 97110, 97150 and 99212. CCI Edit - Procedure 97150 and component procedure 97110 are unbundled. The Standard Policy Statement reads "Mutually exclusive procedures". Reimbursement is therefore not recommended for CPT code 97110.

4. Per 28 Texas Administrative Code §129.5 "(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section..."
    - Date of service, March 5, 2004; disputed CPT code 99070-73.
    - The requestor did not submit a copy of the DWC-73 for review.
    - Review of the CMS-1500 and the EOB provided for review documents that the requestor billed CPT code 99070-73.
    - The requestor is therefore not entitled to reimbursement for CPT code 99070-73.
5. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Review of the documentation finds that:
    - The requestor submitted documentation to support the billing of the disputed services. Reimbursement is therefore recommended according to 28 Texas Administrative Code §134.202.
    - Date of service, February 3, 2004; disputed CPT code 97032. The CPT code 97032 is defined as "Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes." Review of the documentation submitted by the requestor documents that electrical stimulation was applied. The Medicare fee schedule amount for CPT code 97032 is $16.16 x 125% = MAR $20.20. This amount is recommended.
    - Date of service, February 25, 2004; disputed CPT code 97032. The CPT code 97032 is defined as "Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes." Review of the documentation submitted by the requestor documents that electrical stimulation was applied. The Medicare fee schedule amount for CPT code 97032 is $16.16 x 125% = MAR $20.20. This amount is recommended.
    - Date of service, March 1, 2004; disputed CPT code 97032. The CPT code 97032 is defined as "Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes." Review of the documentation submitted by the requestor documents that electrical stimulation was applied. The Medicare fee schedule amount for CPT code 97032 is $16.16 x 125% = MAR $20.20. This amount is recommended.
    - Date of service, March 1, 2004; disputed CPT code. The requestor submitted documentation to support the level of service billed for CPT code 99211. The Medicare fee schedule amount for CPT code 99211 is $22.29 x 125% = MAR $27.86. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $88.46.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $88.46 plus applicable accrued interest per 28 Texas Administrative Code §134.803 for dates of service prior to 5/2/06, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 22, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.